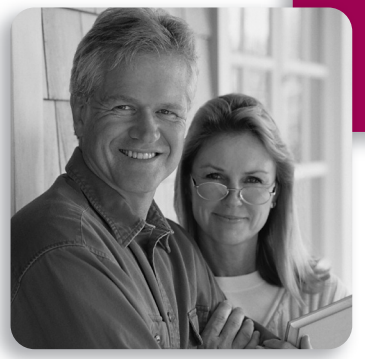
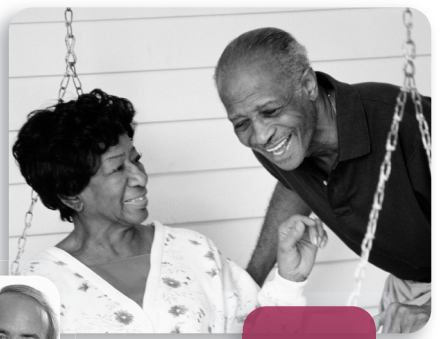
State of Illinois

Department of Central Management Services
Bureau of Benefits



Benefit Choice Options Period

Enrollment Period May 1 - May 31, 2010



Teachers' Retirement Insurance Program

Effective July 1, 2010 - June 30, 2011

Plan Administrators

Who to call for information

Health Care Plan Name/Administrator	Toll-Free Telephone Number	TDD/TTY Number	Website Address
Health Alliance HMO	(800) 851-3379	(217) 337-8137	www.healthalliance.org
Health Alliance Illinois	(800) 851-3379	(217) 337-8137	www.healthalliance.org
HealthLink OAP	(800) 624-2356	(800) 624-2356 ext. 6280	www.healthlink.com
HMO Illinois	(800) 868-9520	(800) 888-7114	www.bcbsil.com/stateofillinois
Humana Health Plan	(866) 427-7478	(800) 833-3301	http://stateofil.humana.com
PersonalCare	(800) 431-1211	(217) 366-5551	www.personalcare.org

Plan Component	Administrator's Name and Address	Customer Service Phone Numbers	Website Address
Health Plans and the Medicare COB Unit	**CMS Group Insurance Division** 201 East Madison Street P.O. Box 19208 Springfield, IL 62794-9208	(217) 782-2548 (800) 442-1300 (800) 526-0844 (TDD/TTY)	www.benefitschoice.il.gov
General Eligibility and Enrollment Information	**Teachers' Retirement System (TRS)** 2815 West Washington P.O. Box 19253 Springfield, IL 62794-9253	(800) 877-7896 (217) 753-0329 (TDD/TTY)	trs.illinois.gov

Plan Administrator information continued on inside back cover.

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Important Changes for Plan Year 2011

(July 1, 2010 through June 30, 2011)

Managed Care Plans (HMO/OAP)

- Physician office visit co-payment increases to $20
- Specialist office visit co-payment increases to $20

Behavioral health benefits have been adjusted.
See page 3 for details.

Consistent with the terms of Public Act 96-0756, the age limits for the monthly premium chart have changed from age 23 to age 24.

You must contact TRS for a Benefit Choice Election Form.

Benefit Choice Period is May 1-31, 2010

The Benefit Choice Period is **May 1 through May 31, 2010,** for all Benefit Recipients. Elections will be effective July 1, 2010. The Benefit Choice Period is the **only** time of the year a Benefit Recipient may change health plans, with the following two exceptions: the Benefit Recipient's permanent address changes affecting availability to the managed care plan or the Primary Care Physician leaves the Benefit Recipient's managed care plan. Benefit Recipients or Dependent Beneficiaries who have never been enrolled in TRIP may enroll during the Benefit Choice Period.

All Benefit Choice changes should be made on the Benefit Choice Election form. Benefit Recipients should complete the form **only** if changes are being made. Dependent Beneficiaries must be enrolled in the same plan as the Benefit Recipient. If you are already enrolled in TRIP and wish to make a change in coverage, please call TRS for a new Benefit Choice form at (800) 877-7896. The Benefit Choice form will only be provided upon request this year. If you are enrolling yourself or an eligible dependent for the first time during the Benefit Choice Period, please contact TRS for a TRIP enrollment application.

During the annual Benefit Choice Period, Benefit Recipients may:

- Change health plans
- Add dependent coverage if never previously enrolled

Additional Reminders About TRIP

To terminate coverage at any time, notify TRS in writing. The cancellation of coverage will be effective the first of the month following receipt of the request. Benefit Recipients and Dependent Beneficiaries who terminate from TRIP may re-enroll only upon turning age 65, becoming eligible for Medicare or when coverage is involuntarily terminated by a former plan.

Participant Responsibilities

It is each participant's responsibility to know plan benefits and make an informed decision regarding coverage elections. Notify the Teachers' Retirement System (TRS) immediately when any of the following occur:

- Change of address
- Qualifying change in status:
  - birth/adoption of a child;
  - marriage, divorce, legal separation, annulment;
  - death of spouse or dependent;
  - dependent(s) loss of eligibility;
  - a court order results in the gain or loss of a dependent;
  - a change in Public Aid recipient status;
  - dependent becomes covered by other group health coverage.
- Change in Medicare status
- Gain of, or change to, other group insurance coverage during the plan year. The participant must provide their Coordination of Benefits (COB) information to TRS as soon as possible.

Behavioral Health Services

The coverage of behavioral health services (mental health and substance abuse) under the benefit plan is being adjusted for the FY 2011 plan year to comply with the federal Mental Health Parity and Addiction Equity Act of 2008. The federal law requires health plans to cover behavioral health services at levels equal to those of the plan's medical benefits.

Teachers' Choice Health Plan:
Behavioral health services will now be included in an enrollee's annual plan deductible and annual out-of-pocket maximum. Behavioral health services will no longer be subject to separate co-payments, limits or other specific provisions. Instead, covered services for behavioral health which meet the plan administrator's medical necessity criteria will be paid in accordance with the Teachers' Choice Health Plan benefit schedule on pages 8 and 9 for in-network and out-of-network providers. Magellan Behavioral Health continues as the plan administrator for behavioral health services under the Teachers' Choice Health Plan. Please contact Magellan for specific benefit information.

Managed Care Plans:
Behavioral health services will continue to be provided under the managed care plans; however, restrictions on the number of allowable visits and hospital days will be eliminated. Covered services for behavioral health must still meet the managed care plan administrator's medical necessity criteria and will be paid in accordance with the managed care benefit schedules on pages 6 and 7. Please contact the managed care plan for specific benefit information.

Disease Management Programs and Wellness Offerings

Disease Management Programs:
Disease Management Programs are utilized by CIGNA and the managed care health plans as a way to improve the health of plan participants. You may be contacted by your health plan to participate in these programs.

Wellness Offerings:
Wellness options and preventive measures are offered and encouraged by CIGNA and the managed care plans. Offerings range from health risk assessments to educational materials and, in some cases, discounts on items such as gym memberships and weight loss programs. These offerings are available to plan participants and are provided to help you take control of your personal health and well-being. Information about the various offerings is available on the plan administrators' websites listed on the inside covers of this book and on the Benefits website.

Coverage and Monthly Premiums

Benefit Recipients who enroll in the Teachers' Retirement Insurance Program (TRIP) receive health, prescription and behavioral health benefits. Dependent Beneficiaries can be enrolled in the program at an additional cost and will have the same health plan as the Benefit Recipient.

The health insurance plans available to TRIP members differ in the benefit levels they provide, the doctors and hospitals you can access and the out-of-pocket cost to you. In general, managed care plans, such as Health Maintenance Organizations (HMOs) and the Open Access Plan (OAP), deliver healthcare through a system of network providers and have a lower monthly premium than the Teachers' Choice Health Plan (TCHP). The TCHP allows plan participants to access any provider nationwide; however, enhanced benefits are available when services are received from a TCHP network provider. The monthly premium is based on the type of coverage selected and the permanent residence on file with TRS.

Type of Plan	Not Medicare Primary Under Age 24	Not Medicare Primary Age 24-64	Not Medicare Primary Age 65 and Above	Medicare Primary* All Ages
Benefit Recipient enrolled in any managed care plan	$59.29	$184.13	$250.87	$72.77
Benefit Recipient enrolled in TCHP when a managed care plan is available in their county of residence	$153.85	$434.21	$653.03	$189.46
Benefit Recipient enrolled in TCHP when a managed care plan is not available in their county of residence	$76.92	$217.11	$326.52	$94.73
Dependent Beneficiary enrolled in any managed care plan	$237.20	$736.50	$1,003.45	$252.09**
Dependent Beneficiary enrolled in TCHP when a managed care plan is available in their county of residence	$307.69	$868.41	$1,306.04	$378.93
Dependent Beneficiary enrolled in TCHP when a managed care plan is not available in their county of residence	$307.69	$868.41	$1,306.04	$284.20**

* You must enroll in both Medicare Parts A and B to qualify for the lower premiums. Send a copy of your Medicare card to TRS. If you or your dependent is actively working and eligible for Medicare, or you have additional questions about this requirement, contact the CMS Group Insurance Division, Medicare Coordination of Benefits (COB) Unit. See inside front cover for contact information.

** Medicare Primary Dependent Beneficiaries enrolled in a managed care plan, or in TCHP when no managed care plan is available, receive a premium subsidy.

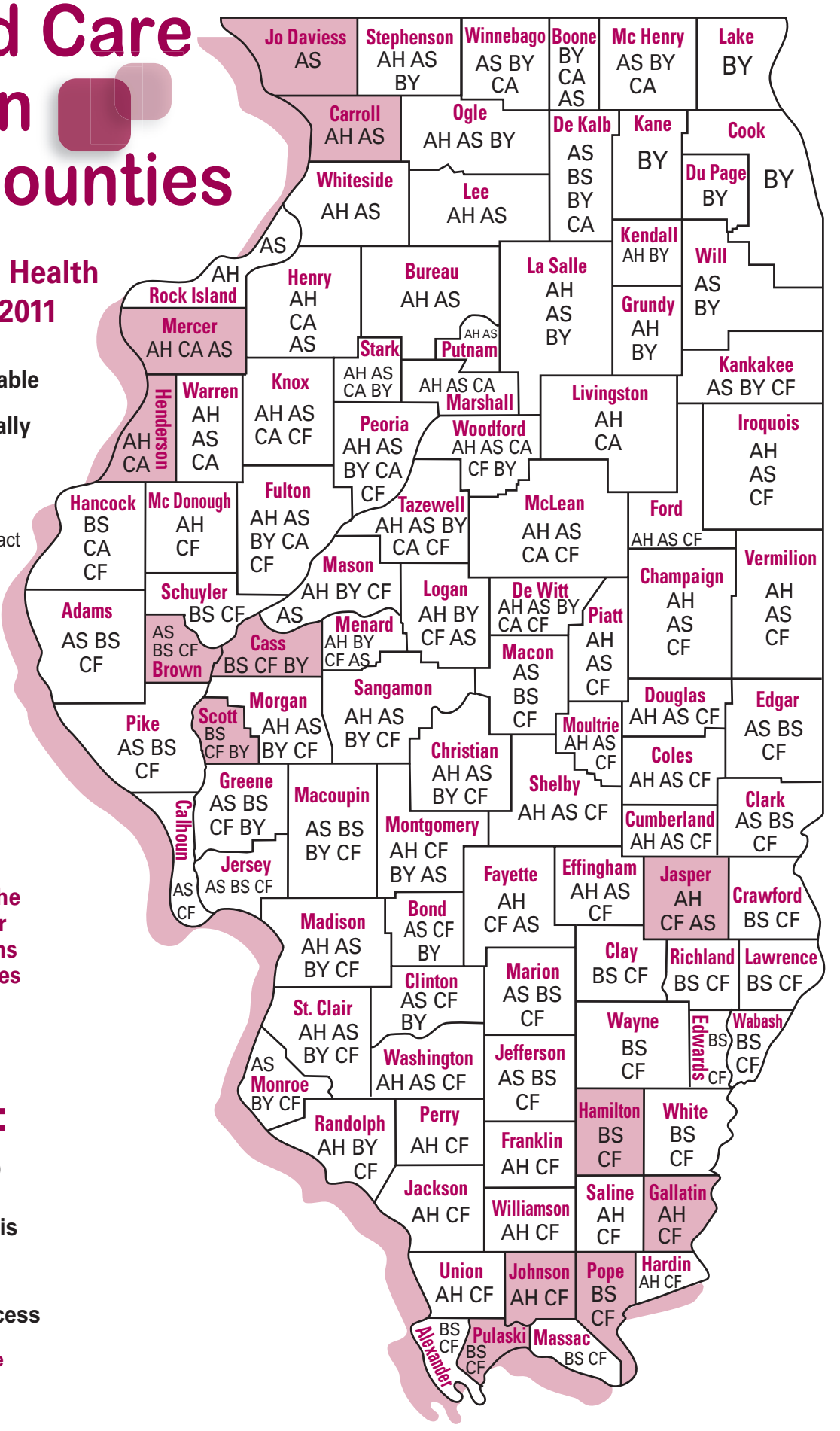
Managed Care Plans in Illinois Counties

TRIP Managed Care Health Plans For Plan Year 2011

Managed Care Available

Managed Care Partially Available

If a two-letter code appears in a shaded county, a managed care provider may be available. Contact the plan for information.



The key below indicates the two-letter carrier codes for HMO and OAP plans. Plans are available in the counties where their code appears.

HMO & OAP Carrier Codes:

AH – Health Alliance HMO
AS – PersonalCare
BS – Health Alliance Illinois
BY – HMO Illinois
CA – Humana Health Plan
CF – HealthLink Open Access

Note: TCHP available Statewide

HMO Benefits

Plan participants must select a Primary Care Physician (PCP) from a network of participating providers. The PCP directs healthcare services and must make referrals for specialists and hospitalizations. When care and services are coordinated through the PCP, the plan participant pays only a co-payment. No annual plan deductibles apply. The HMO coverage described below represents the minimum level of coverage an HMO is required to provide. Benefits are outlined in each plan's Summary Plan Document (SPD). It is the member's responsibility to know and follow the specific requirements of the HMO plan selected. Contact the plan for a copy of the SPD.

HMO Plan Design

Plan year maximum benefit	Unlimited
Lifetime maximum benefit	Unlimited

Hospital Services

Inpatient hospitalization	100% after $250 co-payment per admission
Alcohol and substance abuse	100% after $250 co-payment per admission
Psychiatric admission	100% after $250 co-payment per admission
Outpatient surgery	100% after $150 co-payment
Diagnostic lab and x-ray	100%
Emergency room hospital services	100% after the lesser of $200 co-payment per visit, or 50% of U&C

Professional and Other Services

Physician Office visit (including physical exams and immunizations)	100% after $20 co-payment per visit
Specialist Office visit	100% after $20 co-payment per visit
Outpatient Psychiatric and substance abuse	100% after $20 co-payment per visit
Prescription drugs (formulary is subject to change during plan year)	$10 co-payment for generic $20 co-payment for preferred brand $40 co-payment for non-preferred brand
Durable Medical Equipment	80% of network charges
Home Health Care	100% after $15 co-payment per visit

Some HMOs may have benefit limitations based on a calendar year schedule.

Open Access Plan (OAP) Benefits

The OAP, administered by HealthLink, provides three benefit levels broken into tier groups. Tier I and Tier II require the use of network providers and offer benefits with co-payments and/or coinsurance. Tier III (out-of-network) requires higher out-of-pocket costs, but offers members flexibility in selecting healthcare providers. Tier II and Tier III require a deductible. It is important to remember the level of benefits is determined by the selection of healthcare providers. Members enrolled in the OAP can mix and match providers. The benefits described below represent the minimum level of coverage available in the OAP. Benefits are outlined in the plan's Summary Plan Document (SPD). It is the member's responsibility to know and follow the specific requirements of the OAP plan. Contact HealthLink for a copy of the SPD.

Benefit	Tier I 100% Benefit	Tier II 80% Benefit	Tier III (Out-of-Network) 60% Benefit
Plan Year Maximum Benefit	Unlimited	Unlimited	$1,000,000
Lifetime Maximum Benefit	Unlimited	Unlimited	$1,000,000
Annual Out-of-Pocket Max Per Individual Enrollee Per Family	 $0 $0	 $700 $1,400	 $1,700 $3,600
Annual Plan Deductible (must be satisfied for all services)	$0	$300 per enrollee*	$400 per enrollee*
Hospital Services			
Inpatient	100% after $250 co-payment per admission	80% of network charges after $300 co-payment per admission	60% of U&C after $400 co-payment per admission
Inpatient Psychiatric	100% after $250 co-payment per admission	80% of network charges after $300 co-payment per admission	60% of U&C after $400 co-payment per admission
Inpatient Alcohol and Substance Abuse	100% after $250 co-payment per admission	80% of network charges after $300 co-payment per admission	60% of U&C after $400 co-payment per admission
Emergency Room	100% after $200 co-payment per visit	80% of network charges after $200 co-payment per visit	60% of U&C after lesser of $200 co-payment per visit, or 50% of U&C
Outpatient Surgery	100% after $150 co-payment per visit	80% of network charges after $150 co-payment	60% of U&C after $150 co-payment
Diagnostic Lab and X-ray	100%	80% of network charges	60% of U&C
Physician and Other Professional Services			
Physician Office Visits	100% after $20 co-payment	80% of network charges	60% of U&C
Specialist Office Visits	100% after $20 co-payment	80% of network charges	60% of U&C
Preventive Services, including immunizations, Well Baby care, allergy testing and treatment	100% after $20 co-payment	80% of network charges	Covered under Tier I and Tier II only
Outpatient Psychiatric and Substance Abuse	100% after $20 co-payment	80% of network charges	60% of U&C
Other Services			
Prescription Drugs – Covered through State of Illinois administered plan, Medco Generic $10 Preferred Brand $20 Non-Preferred Brand $40			
Durable Medical Equipment	100%	80% of network charges	60% of U&C
Skilled Nursing Facility	100%	80% of network charges	Covered under Tier I and Tier II only
Transplant Coverage	100%	80% of network charges	Covered under Tier I and Tier II only
Home Health Care	100% after $15 co-payment	80% of network charges	Covered under Tier I and Tier II only

* An annual plan deductible must be met before plan benefits apply. Benefit limits are measured on a plan year. Plan co-payments and deductibles do not count toward the out-of-pocket maximum.

The Teachers' Choice Health Plan (TCHP)

TCHP (administered by CIGNA) is the medical plan that offers a comprehensive range of benefits. Under the TCHP, plan participants can choose any physician or hospital for medical services; however, plan participants receive enhanced benefits, resulting in lower out-of-pocket costs, when receiving services from a TCHP network provider.

The TCHP has a nationwide network (Open Access Plan (OAP)) that consists of physicians, hospitals and ancillary providers. Notification to Intracorp, the TCHP notification administrator, is required for certain medical services in order to avoid penalties. Contact Intracorp at (800) 962-0051 for direction. **Note:** The TCHP and the HealthLink OAP are separate health plans with a separate plan design.

TCHP utilizes Magellan for behavioral health benefits and the Medco retail pharmacy network for prescription benefits.

Plan participants can access plan benefit and participating network information, Explanation of Benefits (EOB) statement and other valuable health information online. To access online links to plan administrators, visit the Benefits website at **www.benefitschoice.il.gov**.

Plan Year Maximums and Deductibles

Lifetime Maximum	$2,000,000
Plan Year Deductible	$500 TCHP Primary Participant (Non-Medicare) $500 Medicare Primary Participant
Additional Deductibles* * These are in addition to the plan year deductible.	Each emergency room visit $400 TCHP hospital admission $200 Non-TCHP hospital admission $400

Out-of-Pocket Maximums

Deductibles and eligible coinsurance payments accumulate toward the annual out-of-pocket maximum. There are two separate out-of-pocket maximums: In-Network and Out-of-Network. Coinsurance and deductibles apply to one or the other, but not both. After the out-of-pocket maximum has been met, coinsurance amounts are no longer required and the plan pays 100% of eligible charges for the remainder of the plan year.

In-Network: $1,200 per individual $2,750 per family per plan year	Out-of-Network: $4,400 per individual $8,800 per family per plan year

The following do not apply toward out-of-pocket maximums:

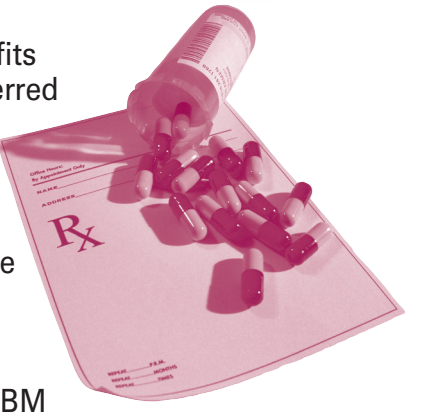
- Prescription Drug benefits, coinsurance or co-payments.
- Notification penalties.
- Ineligible charges (amounts over Usual and Customary (U & C), charges for non-covered services and charges for services deemed not to be medically necessary).
- The portion ($50) of the Medicare Part A deductible the plan participant is responsible to pay.

TCHP - Medical Plan Coverage

Hospital Services	
TCHP Network Hospitals	80% after annual plan deductible. $200 deductible per hospital admission.
Non-TCHP Hospitals	60% after annual plan deductible. $400 deductible per hospital admission.
Outpatient Services	
Lab/X-ray	80% of negotiated fee or 60% of U&C, as applicable, after plan deductible.
Approved Durable Medical Equipment (DME) and Prosthetics	80% of negotiated fee or 60% of U&C, as applicable, after plan deductible.
Licensed Ambulatory Surgical Treatment Centers	80% of negotiated fee or 60% of U&C, as applicable, after plan deductible.
Professional and Other Services	
Provider Services included in the TCHP Network	80% of negotiated fee after the annual plan deductible. U&C charges do not apply.
Provider Services not included in the TCHP Network	60% of U&C after the annual plan deductible for inpatient, outpatient and office visits.
Chiropractic Services - medical necessity required (up to a maximum of 30 visits per plan year)	80% of negotiated fee or 60% of U&C, as applicable, after plan deductible.
Transplant Services	
Organ and Tissue Transplants	80% of negotiated fee after inpatient deductible. Benefits are not available unless approved by the Notification Administrator, Intracorp. To assure coverage, the transplant candidate must contact Intracorp prior to beginning evaluation services.
Behavioral Health Services	
Magellan administers the TCHP Behavioral Health Services benefit. Authorization is required for all behavioral health services. For authorization procedures, see the Benefits Handbook or call Magellan at (800) 513-2611.	

Network providers are subject to change throughout the plan year. Always call the respective plan administrator to verify participation of a specific provider.

Prescription Drug Benefit



Plan participants enrolled in any TRIP health plan have prescription drug benefits included in the coverage. All prescription medications are compiled on a preferred drug list ("formulary list") maintained by each health plan's Prescription Benefit Manager (PBM). Formulary lists categorize drugs in three levels: generic, preferred brand and non-preferred brand. Each level has a different co-payment amount. Please note that when a pharmacy dispenses a brand drug for any reason and a generic is available, the plan participant must pay the cost difference between the brand product and the generic product, plus the generic co-payment. This cost difference does not apply toward the annual prescription out-of-pocket maximum. Plan participants who have additional prescription drug coverage, including Medicare, should contact their plan's PBM for Coordination of Benefits (COB) information. TCHP has 20% coinsurance with minimum and maximum co-payments. TCHP plan participants can receive a 90-day supply of maintenance medication through the Mail Order Program for two co-payments and applicable coinsurance.

PRESCRIPTION DRUG CO-PAYS FOR ALL MANAGED CARE PLANS (30-DAY SUPPLY)	
Generic	$10
Preferred (Formulary) Brand	$20
Non-Preferred Brand	$40

PRESCRIPTION DRUG CO-PAYS/COINSURANCE FOR TCHP (30-DAY SUPPLY)		
	Minimum	Maximum
Generic	$7	$50
Preferred (Formulary) Brand	$14	$100
Non-Preferred Brand	$28	$150

- Annual prescription drug out-of-pocket maximum of $1,500 applies.
- After meeting the $1,500 out-of-pocket maximum, prescriptions are covered at 100%.
- Out-of-network claims do not count toward this annual out-of-pocket maximum.
- 20% coinsurance with minimum and maximum co-payments.
- The maximum supply at one fill is 60 days.
- Prescription drug benefits are independent of other medical services and are not subject to the medical plan year deductible or the medical out-of-pocket maximums.
- Prescription plan benefits are included in the lifetime maximum.

Coverage for specific prescription drugs may vary depending upon the health plan. It is important to note that formulary lists are subject to change any time during the plan year. To compare formulary lists, cost-savings programs and to obtain a list of pharmacies that participate in the various health plan networks, plan participants should visit the website of each health plan they are considering. Certain health plans notify plan participants by mail when a prescribed medication they are currently taking is reclassified into a different formulary list category. If a formulary change occurs, plan participants should consult with their physician to determine if a change in prescription is appropriate.

Plan Participants (Members and Dependents) Eligible for Medicare

What is Medicare?

Medicare is a federal health insurance program for the following:

- Participants age 65 or older
- Participants under age 65 with certain disabilities
- Participants of any age with End-Stage Renal Disease (ESRD)

Medicare has the following parts to help cover specific services:

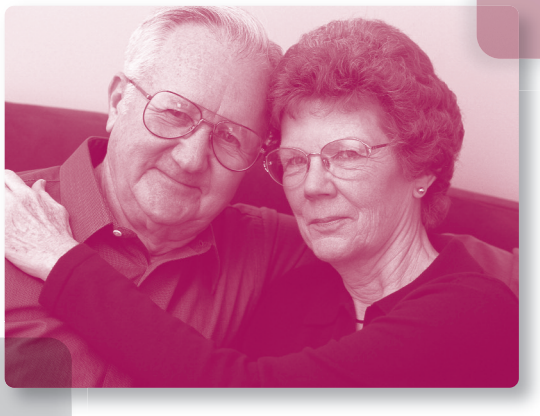
- **Medicare Part A** (Hospital Insurance): Part A coverage **is required** for plan participants eligible for the coverage at a premium-free rate. The Social Security Administration (SSA) determines eligibility for participants who have earned enough credits based on their own work history or that of a spouse who is at least 62 years of age (when applicable).
- **Medicare Part B** (Outpatient and Medical Insurance): Part B **is not required**. Medicare Part B requires a monthly premium contribution (amount determined by the SSA).
- **Medicare Part D** (Prescription Drug Insurance): Part D coverage **is not required**. Medicare Part D coverage requires a monthly premium contribution, unless the participant qualifies for extra-help assistance. In order to apply for Medicare benefits, plan participants are instructed to contact their local SSA office or call 1-800-772-1213. Plan participants may also contact the SSA via the internet at www.socialsecurity.gov to sign up for Medicare Part A benefits.

To ensure that healthcare benefits are coordinated appropriately and the correct premium is charged, plan participants must notify TRS when they become eligible for Medicare and send TRS a copy of their Medicare identification card. Plan participants should contact the State of Illinois CMS Medicare COB Unit for any questions via phone at 1-800-442-1300 or 217-782-7007.

Teachers' Retirement Insurance Program (TRIP) Medicare Requirements

Each plan participant must contact the SSA and apply for Medicare benefits upon turning the age of 65. If the SSA determines that a plan participant is eligible for Medicare Part A at a premium-free rate, **TRIP requires** that the plan participant accept the Medicare Part A coverage.

If the SSA determines that a plan participant is not eligible for premium-free Medicare Part A based on his/her own work history or the work history of a spouse at least 62 years of age (when applicable), the plan participant must request a written statement of the Medicare ineligibility from the SSA. Upon receipt, the written statement must be forwarded to TRS. Plan participants who are ineligible for premium-free Medicare Part A, as determined by the SSA, are not required to enroll in Medicare.



Plan Participants (Members and Dependents) Eligible for Medicare (cont.)

Retirees, Survivors and Disabled Participants without Current Employment Status (and their applicable Dependents)

Plan participants (including dependents) who are retired, a survivor or a disability recipient without Current Employment Status (such as no longer working due to a disability) who are eligible for premium-free Medicare Part A must enroll in Medicare Part A, but may decline enrollment in Medicare Part B. However, even though TRIP does not require plan participants to enroll in Medicare Part B, **participants who receive the lower Medicare primary TRIP premium (due to having both Medicare Parts A and B) are required to maintain their enrollment in Medicare A and B.** Participants receiving the Medicare primary premium will be subject to the higher non-Medicare primary premium if disenrollment from Medicare Part B occurs. Furthermore, the participant will be charged the higher premium rate retroactively to the date Medicare Part B was dropped. **Plan participants who drop Medicare Part B coverage must notify TRS immediately and provide the date the coverage termed.**

For the TRIP premium rates, please refer to the monthly premium chart on page 4.

Plan Participants Eligible for Medicare on the Basis of End Stage Renal Disease (ESRD):

Plan participants at any age who are eligible for Medicare benefits based on End Stage Renal Disease (ESRD) must contact the State of Illinois CMS Medicare COB Unit for information regarding the Medicare requirements and to ensure the proper calculation of the 30-month Coordination of Benefit Period.

Each plan participant who becomes eligible for Medicare is required to submit a copy of his/her Medicare card to his/her Group Insurance Representative (GIR) at the Teachers' Retirement System (TRS). You may contact TRS at 1-800-877-7896.

Plan Administrators

Who to call for information

Plan Component	Contact For:	Administrator's Name and Address	Customer Service Contact Information
Teachers' Choice Health Plan (TCHP) Medical Plan Administrator	Medical service information, network providers, claim forms, ID cards, claim filing/resolution and predetermination of benefits	**CIGNA** Group Number 2457482 **CIGNA HealthCare** P.O. Box 5200 Scranton, PA 18505-5200	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com/soi.html
TCHP Notification and Medical Case Management Administrator	Notification prior to hospital services Non-compliance penalty of $1,000 applies	**Intracorp, Inc.**	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com/soi.html
Prescription Drug Plan Administrator TCHP (1402TD3) Health Alliance Illinois (1402TBS) HealthLink OAP (1402TCF)	Information on prescription drug coverage, pharmacy network, mail order, specialty pharmacy, ID cards and claim filing	**Medco** Group Number: 1402TD3, 1402TBS, 1402TCF **Paper Claims:** Medco Health Solutions P.O. Box 14711 Lexington, KY 40512 **Mail Order Prescriptions:** Medco P.O. Box 30493 Tampa, FL 33630-3493	(800) 899-2587 (nationwide) (800) 759-1089 (TDD/TTY) www.medco.com
TCHP Behavioral Health Administrator	Notification, authorization, claim forms and claim filing/resolution for Behavioral Health Services	**Magellan Behavioral Health** Group Number 2457482 P.O. Box 2216 Maryland Heights, MO 63043	(800) 513-2611 (nationwide) (800) 526-0844 (TDD/TTY) www.MagellanHealth.com

DISCLAIMER

The State of Illinois intends that the terms of this plan are legally enforceable and that the program is maintained for the exclusive benefit of the Teachers' Retirement Insurance Program (TRIP) Benefit Recipients. TRIP reserves the right to change any of the benefits and contributions described in this Benefit Choice Options booklet. This booklet is produced annually and is intended to supplement the Benefits Handbook. If there is a discrepancy between the Benefit Choice Options booklet, the Benefits Handbook and state or federal law, the law will control.

Illinois Department of Central Management Services
Bureau of Benefits
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Springfield, IL 62794-9208

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